



DI_{VERSIFIED} BENEFIT SER_{VICES}, INC.

Dedicated to Excellence in Benefit Management Solutions

Claim Form Instructions 125-Flexible Spending Account (FSA)

Top Section of the Form:

1. Print your full name, email address, social security number and the name of your employer.
2. Sign and date the form where indicated (**required**).

Claim Type I - Dependent Care Reimbursement Account:

1. Fill in total amount of expenses incurred. This is the total amount charged by your dependent care provider and corresponds with the dates of services.
2. If the dependent care provider is a private individual, please provide his/her social security number. However, if the provider is a business (such as a daycare center), provide its federal tax identification number.
3. List the incurred dates of service. Please note we cannot accept future dates of service and all dates must fall within the plan year.
4. Have the dependent care provider sign on the indicated line **or** you can provide a copy of your receipt.

Claim Type II - Medical Reimbursement Account:

1. Fill in total amount of expenses incurred.
2. The dates of service must be within the plan year. **This does not mean when you paid for the item or services; rather, when the services were rendered.**
3. Attach copies (**not originals**) of proper documentation to the claim form prior to sending to DBS. "Proper Documentation" must include the following: a.) date(s) of service b.) your out-of-pocket expense incurred, and c.) a description of what the expense was. Multiple pieces of documentation may be attached to one form. The following are examples of proper documentation:
 - **Explanation of Benefits (EOB):** This is a form provided to you by your insurance company after receiving services from a physician, hospital or medical clinic. It shows the date of service, service provided, amount covered by insurance and any remaining amount owed by you for the service.
 - **Provider Billing Statements/Invoices:** This is the invoice from a medical, dental or vision provider, showing the date of service, service provided and the amount you owe for the service (if not covered by insurance).
4. If your claim is for orthodontia (braces), please check the appropriate box on the claim form. Proper documentation can include a copy of the orthodontia payment coupon, receipts, bills, or EOB's.

Claim Type III - Independent Premium Feature:

1. Fill in total amount of expenses incurred.
2. List the insurance premium billing period dates.
3. This account is solely for independent private insurance, not for claiming reimbursement of group insurance premiums paid by your employer
4. Attach a copy of the independent insurance premium billing to the form.

Submitting Your Claim Form:

1. When your claim form is complete and copies of the documentation are attached to it, you may send it to us via mail or fax. Our address and fax number is located at the top right corner of the claim form.

For assistance please call our Customer Service Team at (800) 234-1229

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